

## BEYOND A WESTERN BIOETHICS?

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*[Like theology and ethics generally, bioethics has increasingly developed a global consciousness. Controversies over AIDS research and access to affordable AIDS treatment have generated new awareness about the importance of international collaboration as well as the difficulty of achieving moral consensus across economic, political, and cultural divides. Advances in scientific and medical knowledge through initiatives such as the Human Genome Project invite new questions about the nature of health care as a common good. This budding global consciousness serves as a starting point for examining contemporary challenges to the secular, principle-based, Western bioethics that has dominated national and international debate for three decades.]*

PRINCIPALISM'S TROUBLES ARE well known. Critics bearing the concerns of feminism, religion, and multiculturalism have registered their discontent with the state of contemporary bioethics in the U.S.A. Heavily indebted to the principle-based method that became popular through James F. Childress and Tom L. Beauchamp's influential text, *Principles of Biomedical Ethics*, bioethics has been called to task for its emphasis on rights and duties over the development of character and virtue, as well as for its relative inattention to social, religious, and cultural features of moral experience and moral agency.<sup>1</sup> Chief among the complaints has been its

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<sup>1</sup> Often used disparagingly, "principlism" refers to the application of four prima facie principles: autonomy, nonmaleficence, beneficence, and justice, to particular cases of medical decision-making or policy formation. See Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 5<sup>th</sup> edition (New York: Oxford University, 2001). That *Principles of Biomedical Ethics* is now in its fifth edition (with significant revisions along the way) testifies both to the scale of its influence and the extent of the critique brought to bear on the method. For a helpful collection of critical reflections on "principlism," see *A Matter of Principles? Ferment in U.S. Bioethics*, ed. Edwin R. DuBose, Ron Hamel, Laurence J. O'Connell (Val-

perceived preoccupation with the maximization of individual autonomy and its willingness to accept as its goal the achievement of minimum consensus among “moral strangers.”<sup>2</sup>

Increasingly, the “critique from within” is joined by a “critique from without.” As bioethics has gradually developed a global consciousness, new voices from outside North America and Europe have emerged including voices from Africa, Asia, and Latin America, raising even more fundamental questions of adequacy and credibility. At issue is not only the relative emphasis within bioethics on rights versus responsibilities, on autonomy versus beneficence, but the international dominance of an approach to ethical issues in health and medicine that is drawn principally from Western philosophical traditions (indebted, in particular, to Kantian deontology and utilitarianism) and developed within institutional settings of the West and in light of European and North American legal and regulatory frameworks.

What follows is an attempt to survey some of the key challenges posed to bioethics by this emergent global consciousness and to suggest what might be involved in moving “beyond a Western bioethics.” It is an attempt, in particular, to show how the moral geography for bioethics (i.e., the field of moral problems and responses) shifts when viewed from the perspective of the “two-thirds world.”<sup>3</sup> Finally, this section concludes with some reflections on the critical and constructive role of theological ethics in forging a global bioethics.

### HEALTH AND MEDICINE: FROM LOCAL TO GLOBAL

Commenting on current debates in bioethics, Lori Knowles observes that “globalization is often discussed as if it were a recent phenomenon relating primarily to the development of world financial markets and improvements

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ley Forge, Penn.: Trinity International, 1994). For a look at the debate over the role of religious values and languages in contemporary bioethics see the journal *Christian Bioethics*.

<sup>2</sup> The term “moral strangers” was introduced by H. Tristram Engelhardt to describe the fact of moral pluralism with which both method and practice in contemporary bioethics must contend. See H.T. Engelhardt, Jr., *The Foundations of Bioethics*, 2<sup>nd</sup> ed. (New York: Oxford University, 1966). For a helpful exposition and critique of this notion and of Engelhardt’s solution to the problem of moral pluralism, see Kevin Wm. Wildes, S.J., *Moral Acquaintances: Methodology in Bioethics* (Notre Dame: University of Notre Dame, 2000).

<sup>3</sup> Many people prefer the term “two-thirds world” to “the developing world” or “the third world” because it reflects the fact that much of the world’s population lives under conditions of economic marginalization relative to the developed world. Here I also use the term “the South” to indicate the relative concentration of impoverished nations in the Southern hemisphere.

in information and travel technologies.”<sup>4</sup> Indeed, it is now becoming commonplace to describe this present era, with its mass consolidation of economic interests, rapid communication, and heightened sense of interdependence and “intercultural fertilization” as witnessing the birth of a “*new* global culture.”<sup>5</sup> In the same way, most discussions of the global implications of developments in science and technology today are prefaced by an acknowledgment of a newly generalized sense of vulnerability, especially in the West, a sense, as British Prime Minister Tony Blair put it, of “the fragility of our frontiers in the face of the world’s new challenges.”<sup>6</sup> As Knowles goes on to argue, however, neither globalization nor shared risk *per se* is new. Globalization is, of course, “an ancient process, beginning with mercantile and cultural exchanges and facilitated by [incremental] advances in transportation.”<sup>7</sup> And, as others have pointed out, the history of medicine contains many examples, from the Athenian plague of 430 B.C. to the influenza pandemic of the early 20th century, of disease overrunning national boundaries (or, as one commentator put it, of “involuntary microbiological warfare”).<sup>8</sup>

Still, it is undeniable that today we are witnessing the flow of information, people, and money at a pace, range, and depth of integration previously unknown. In the wake of what has been called the “death of distance,” traditional distinctions between domestic and international concerns are losing their salience, replaced with an awareness that many challenges—for instance, in public health, economic development, and environmental stability—can only be understood and addressed as global challenges.<sup>9</sup>

Three factors in the “globalization of bioethics” are worth noting: the AIDS pandemic; controversies over access to life-saving drugs and the conduct of research; and the success of the Human Genome Project.

<sup>4</sup> Lori P. Knowles, “The Lingua Franca of Human Rights and the Rise of a Global Bioethic,” *Cambridge Quarterly of Healthcare Ethics* 10 (2001) 253–63, at 253.

<sup>5</sup> The term “intercultural fertilization” is used by T. Howland Sanks, S.J., in “Globalization and the Church’s Social Mission,” *Theological Studies* 60 (1999) 625–51, at 625.

<sup>6</sup> Tony Blair, Labor Party Conference, Brighton, October, 2001. As quoted in Julio Frenk and Octavio Gomez-Dantes, “Globalisation and the Challenges to Health Systems,” *British Medical Journal* 325 (7/13/2002) 95–97, at 95.

<sup>7</sup> Knowles, “The Lingua Franca of Human Rights and the Rise of a Global Bioethic” 253.

<sup>8</sup> Frenk and Gomez-Dantes, “Globalisation and the Challenges to Health Systems” 95.

<sup>9</sup> *Ibid.*

### “The World Has AIDS”

By the best estimates, more than 20 million people worldwide have already died of AIDS and at least 42 million more are infected with HIV. Rates of HIV infection and deaths from AIDS are especially high in sub-Saharan Africa, with one out of every ten adults infected.<sup>10</sup> According to the World Health Organization, of the estimated five to six million people in developing countries in need of AIDS treatment, less than 300,000 have access to the antiretroviral therapy that has become standard in the United States. In Africa, only one percent of those infected with HIV have access to effective treatment. At the United States General Assembly Meeting on HIV/AIDS on September 22, 2003, WHO declared the lack of access to HIV treatment “a global health emergency.”<sup>11</sup>

The emergence of AIDS illustrates several features of the relationship of globalization to health and medicine. First and most obvious, AIDS (and more recently SARS) represents the exponential shift in the potential transfer of risks made possible through existing forms of international travel and modern trends in migration. As noted earlier, the transmission of communicable diseases across national and regional boundaries is not a new phenomenon. What is new is what Julio Frenk and Octavio Gomez-Dantes call “the scale of microbial traffic.” “The explosive increase of world travel produces thousands of potentially infectious contacts daily. Even the longest intercontinental flights are briefer than the incubation period of any human infectious disease.”<sup>12</sup> As much in perception as in reality, the devastating spread of AIDS symbolizes a core theme in definitions of globalization: local happenings are shaped profoundly by events unfolding a world away and vice versa. Whatever is “out there” can wind up on one’s doorstep in a flash.<sup>13</sup>

<sup>10</sup> World Health Organization, “Global AIDS Treatment Emergency,” *Fact Sheet* 274 (September 2003); on the World Wide Web at <http://www.who.int/mediacentre/factsheets/2003/fs274en/print.html>

<sup>11</sup> *Ibid.*

<sup>12</sup> Frenk and Gomez-Dantes, “Globalisation and the Challenges to Health Systems” 95. See also Yehuda Shoenfeld and Joshua Shemer, “Why Viral (SARS, Ebola and AIDS) Epidemics Now?” *Harefu* 142 (May 2003) 324–25. Several observers of this phenomenon of “rapid shared risk” note that advances in communication media, combined with marketing strategies, add yet another dimension to this reality: the mass exportation of ideas and practices with health implications. One prime example is the aggressive marketing, on a global scale, of tobacco products. See “Is Globalization Good for Your Health?” *Bulletin of the World Health Organization* 79 (2001) 827–33.

<sup>13</sup> See Anthony Giddens, *The Third Way: The Renewal of Social Democracy* (Malden, Mass.: Polity, 1998).

Moreover, the wide disparity between the course of AIDS in the economically developed world generally (where rates of HIV infection and deaths from AIDS have stabilized or fallen) and its course in the poor countries of the South reveals a world as divided by economic, political, and cultural realities as united in the human susceptibility to disease. In characterizing access to treatment in sub-Saharan Africa as a “*global emergency*,” WHO highlights the economic toll of the AIDS pandemic: “By robbing communities and nations of their greatest asset—their people—AIDS drains the human and institutional capacities that drive sustainable development. This, in turn, distorts labour markets, disrupts production and consumption, erodes productive and public sectors and ultimately diminishes national wealth.”<sup>14</sup> In other words, AIDS unaddressed guarantees the intergenerational legacy of widespread poverty in this region, a consequence that has implications for the whole world. But AIDS in sub-Saharan Africa is a *global* emergency in another sense as well: local capacity to address the public health threat of HIV/AIDS is dependent in important ways on relationships and forces that are global in scale, e.g., international trade policies and practices that have acted, until recently, to keep affordable antiretroviral drugs out of reach; international lending relationships that in some cases force choices between health-care expenditures and debt repayment; and Western-controlled commercial markets that play a powerful role in establishing international priorities for science and medicine.<sup>15</sup>

If the scale of the AIDS pandemic has made obvious the need for coordinated, international cooperation in the face of shared public health challenges, controversies surrounding efforts toward collective action have made the complex negotiation between local and global painfully clear. For one thing, experience even within regions shows that efforts to prevent or treat HIV/AIDS will fail if insufficient attention is paid to local circumstances, beliefs, and customs. Reflecting on programs aimed at containing the spread of AIDS in rural India, epidemiologist Sudha Sivaram argues that “although the Indian government outlines a very sound AIDS policy, there are . . . gaps in the translation of this policy to action,” gaps having to do with regional health-care infrastructure (e.g., lack of skills and resources among medical providers to effectively manage HIV infection) as well as the sociocultural context for care (e.g., stigmatization within the commu-

<sup>14</sup> World Health Organization, “Global AIDS Treatment Emergency.”

<sup>15</sup> See Veena Das, “Public Good, Ethics, and Everyday Life: Beyond the Boundaries of Bioethics,” *Daedalus* 128 (Fall, 1999) 99–134; also, “The Two-Thirds World has AIDS: Deconstructing the Politics of Health,” Report on Seminars at the Parliament of the World’s Religions, South Africa (1999) on the world-wide-web at <http://web.uct.ac.za/depts/ricsa/confer/parl1999/pwr-rpt3.htm>

nity that acts to discourage infected individuals from seeking help).<sup>16</sup> Citing studies by medical anthropologists, Veena Das concludes that, even with Indian governmental mandates for providing treatment, “availability of drugs does not mean that they are used in a manner considered appropriate according to expert norms of biomedicine . . . the meaning of medicines at the local levels derives from the way in which they tend to be embedded into different cosmologies, concepts of the body, and notions of interrelatedness.”<sup>17</sup>

The problem of how to relate particular needs and contexts to general norms or policies, i.e., what forms cooperation should take in response to the global crisis of AIDS is perhaps most clearly illustrated in the deeply controversial issues of access to retroviral drugs and the ethics of international research.

### “Dying for a Break”

In prosperous countries, the availability of antiretroviral (ARV) drugs has transformed HIV/AIDS from a generally terminal condition to a potentially manageable condition. According to WHO, in the United States “the introduction of triple combination ARV therapy in 1996 led to a 70% decline in deaths attributable to HIV/AIDS.”<sup>18</sup> Investments in ARV drugs have been significant. In the United States, triple combination therapy costs for each patient an average of \$10,000 per year. At the same time, for those countries who can find a way to afford it, providing universal access to effective therapy realizes significant savings over the long term. Brazil provided universal access to ARV therapy between 1996 and 2002 at a cost of US\$1.8 billion. During that period, “Brazil saw a decrease in mortality rates of 40%–70%, morbidity rates of 60%–80%, plus a seven-fold drop in hospitalization needs.” The savings in expenditures for hospital and ambulatory care services amounted to US\$2.2 billion.<sup>19</sup>

Much of this period has been marked by bitter debates over the rights of pharmaceutical corporations to market their products freely, under the protection of international trade and patent agreements, versus the rights of the most marginalized within the world health system to the drugs needed to save their lives and the future of their countries. In part, the

<sup>16</sup> Sudha Sivaram, “AIDS Care and Human Rights in Rural India: Translating Policy into Practice,” *Ebio: Journal of Asian and International Bioethics* 12 (2002) 214–16, at 215. See also, Angela Wasunna, “The Front Line in the African AIDS Crisis,” *Hastings Center Report* (October 2001) 12.

<sup>17</sup> Das, “Public Good, Ethics, and Everyday Life: Beyond the Boundaries of Bioethics” 117.

<sup>18</sup> World Health Organization, “Global AIDS Treatment Emergency.”

<sup>19</sup> *Ibid.*

debate has turned on the question of whether patent laws, which are defended as an important means to encourage the development of new drugs, should be suspended under the emergency conditions presented by the AIDS pandemic—or even completely rethought in light of persistent global inequities.<sup>20</sup> Brazil's success story is a case in point: Brazil achieved universal access to ARV therapy by manufacturing its own generic drugs in defiance of patent restrictions.<sup>21</sup> In part, the debate has been about the deeper question of how one ought to think about essential drugs, that is, whether they are simply a product or form of property (to be distributed at the discretion of the producer) or whether they are “global public goods,” subject to the claims and obligations of the common good.

Several proposals have been advanced for addressing the problem of access to lifesaving drugs for impoverished and AIDS-stricken countries, some of which have been acted upon in some form in conjunction with other attempts to shore up public health infrastructure: (1) the development of a Global Fund for subsidizing the purchase of patented medicines; (2) funneled debt forgiveness; (3) purchase of patents by an international body for emergency production of generic drugs; and (4) two-tiered (equity) pricing.<sup>22</sup> One of the most interesting proposals was offered by Jean Lanjouw. She argues that developers of drugs that combat global diseases should have intellectual property rights in “rich country markets or poor country markets, but not in both.”<sup>23</sup> Thus, if the sponsor of a new drug

<sup>20</sup> Some have questioned this defense of patent laws given the fact that only a small number of the drugs produced treat conditions that primarily affect people in the two-thirds world.

<sup>21</sup> See “Access to Essential Drugs,” *Developing World Bioethics* 2 (2002) 99–103.

<sup>22</sup> Jillian Clare Cohen and Patricia Illingworth, “The Dilemma of Intellectual Property Rights for Pharmaceuticals: The Tension Between Ensuring Access of the Poor to Medicines and Committing to International Agreements,” *Developing World Bioethics* 3 (2003) 27–47. The World Health Organization notes in September of 2003 that [as a result of considerable international pressure] there has been a significant reduction in the price of ARV drugs offered to sub-Saharan Africa (from US\$10,000 a year to US\$300); in 2003, the World Trade Organization began allowing impoverished nations to import generic versions of patented drugs under some circumstances; and a Global Fund has been established to address AIDS, tuberculosis and malaria. WHO notes, however, that serious attention to health care infrastructure in the hardest-hit countries is necessary if the goal of having three million people on ARV therapy by 2005 is to be achieved. See, World Health Organization, “Global AIDS Treatment Emergency.” See also, “WHO Welcomes New Initiative to Cut the Price of AIDS Medicines,” *Press Release*, October 24, 2003.

<sup>23</sup> As summarized in David Dollar, “Is Globalization Good for Your Health?” *Bulletin of the World Health Organization* 79 (2001) 827–33. Original citation: Jean Lanjouw, “A Patent Policy Proposal for Global Diseases,” Paper Presented at the Annual Bank Conference on Developmental Economics, The World Bank, Wash-

chooses to enforce patent rights in the “rich country markets,” he or she may not enforce them in “poor country markets,” thereby creating healthy competition for price in the latter market. It is doubtful whether such a proposal would succeed politically. However, it is a novel way of attempting to make the market responsive to the specific needs of the least well-off countries.

David Dollar argues that the “the controversy over AIDS drugs for developing countries epitomizes what is both good and bad about globalization.”<sup>24</sup> The development of ARV drugs is a prime example of the kind of “productivity for human welfare” that is encouraged by the combination of a large market and protection for intellectual property rights. At the same time, it is clear from the outcry over the initial unwillingness of pharmaceutical corporations to cut prices on humanitarian grounds that there needs to be what Dollar calls “complementary policies” in developing countries and “further improvements in the international architecture, for example in intellectual property rights.”<sup>25</sup> Dollar echoes concerns raised by others that “the accelerating trend toward globalization, without the requisite safeguards and protections of human rights” will only deepen disparities in health and economic development.<sup>26</sup>

While controversies over drug pricing illustrate the kinds of issues to which bioethics must respond in a global era, disagreements over the conduct of international research, particularly in countries with minimal health-care resources, illustrate the “globalizing” of bioethics itself. Intense debates have centered, e.g., on the use of placebos in ARV and vaccine trials especially in research initiated in the United States and Europe and conducted in countries such as Africa, Thailand, and the Philippines. Many have argued that HIV/AIDS trials using placebos violate widely accepted norms such as the *International Ethical Guidelines for Biomedical Research Involving Human Subjects*, adopted by the Council for International Organizations of Medical Sciences (CIOMS), which hold that “researchers working in developing countries have an ethical responsibility to provide treatment that conforms to the standard of care in the sponsoring country, when possible.”<sup>27</sup> Since all HIV/AIDS patients in need of retroviral therapy are eligible to receive it in countries such as the United States, the

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ington, D.C., May, 2001. See also, Griffin Trotter, “Buffalo Eyes: A Take on the Global HIV Epidemic,” *Cambridge Quarterly of Healthcare Ethics* 12 (2003) 434–43.

<sup>24</sup> Dollar, “Is Globalization Good for Your Health?” 440.

<sup>25</sup> *Ibid.*

<sup>26</sup> Zulfiqar Ahmed Bhutta, “Ethics in International Health Research: A Perspective from the Developing World,” *Bulletin of the World Health Organization* 80 (2002) 114–21.

<sup>27</sup> Charles Weijer and James A. Anderson, “The Ethics Wars: Disputes over

standard of care in research sponsored by the United States would be much beyond what would be available in virtually all places in the South where such research is likely to be conducted. Many ethicists have argued that trials under these conditions violate basic human rights; others (in many cases speaking on behalf of the research subjects) have argued for a pragmatic, “realistic” approach that accepts the “less than best” as a fact of life in many parts of the world and that focuses research efforts on the development of locally feasible solutions to self-defined public health needs.<sup>28</sup>

The most recent version of the CIOMS guidelines, revised in light of this controversy, points to some of the specific challenges now being raised to the basic assumptions of research ethics. The introduction to the document acknowledges that “the challenge to international research ethics is to apply universal ethical principles [e.g., respect for autonomy and nonmaleficence] to biomedical research in a multicultural world with a multiplicity of health-care systems and considerable variation in standards of health care.”<sup>29</sup> While continuing to defend the universality of moral principles that has been the hallmark of research ethics since the end of World War II, the document’s drafters nonetheless recognize that various forms of “local knowledge” must come into play as principles are applied in particular circumstances, e.g., assessments of the capacities and limitations of various agents and institutions, expectations for change, and the intersection of cultural and religious meanings. One implication of this awareness is an emphasis on the importance of developing local expertise in bioethics and encouraging researcher-community partnership.<sup>30</sup> Still another implication is the acknowledgment that some disagreements, especially those involving what could be called “conflicting moral world views” may be irresolvable. Noting persistent, widespread disagreement on the issue, the revised guidelines do not attempt to give a single interpretation of the conditions under which it is ethical to use placebos in international drug trials.

In the background of controversies over access to lifesaving drugs and

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International Research,” *Hastings Center Report* 31 (2001) 18–20, at 18. There have also been debates over the content of the obligation to obtain informed consent in cultures in which group or family authority is privileged over individual authority.

<sup>28</sup> See, e.g., Angeles Tan Alora, “The Virtues and Vices of Dumping,” *Beyond a Western Bioethics: Voices from the Developing World*, Angeles Tan Alora and Josephine M. Lumitao, ed. (Washington: Georgetown University, 2001) 119–22.

<sup>29</sup> *International Ethical Guidelines for Biomedical Research Involving Human Subjects*, Council for International Organizations of Medical Sciences in collaboration with the World Health Organization (Geneva, 2002).

<sup>30</sup> See Abdool Karim, “Globalization, Ethics and AIDS Vaccines,” *Science* 288 (June 23, 2000) 2129. Also, Angela Wasunna, “The Front Line in the African AIDS Crisis,” *Hastings Center Report* (September–October, 2001) 12

the conduct of medical research is the question of how, in this “multicultural world” with its “multiplicity of health-care systems and considerable variation in standards of health care” one is to define the sphere of *global public goods* and, more important, ensure equity of access to those goods. One gets a glimpse of the seriousness and depth of the challenge when one turns from the HIV/AIDS pandemic to consider briefly recent successes in mapping the human genome.

### Whose “Holy Grail”?

“Although advances in genetic science create the potential for dramatic progress in rich and poor states, they also pose profound national and global policy concerns, including the potential impact of the scientific developments on human rights and public health.”<sup>31</sup> Allyn Taylor’s observation captures well the mix of anticipation and anxiety that has met developments in genetic science and technology. It is widely agreed that the Human Genome Project, the multimillion dollar, multilateral initiative to map the human genome, holds significant promise for addressing threats to health and well-being, both those that more often affect persons in the developed world and those specific to economically struggling areas. Responding to a report issued by the World Health Organization in 2002 entitled “Genomics and World Health,” a team of Canadian researchers showed that, although most genetic research currently serves the interests of industrialized nations, certain advancements in biotechnology have great potential for addressing some of the most intractable public health problems faced by the two-thirds world, e.g., “modified molecular technologies for affordable, simple diagnosis of infectious diseases; recombinant technologies to develop vaccines and efficient vaccine delivery systems against the most common infectious; and technologies aimed at sanitation and bioremediation.”<sup>32</sup>

Enthusiasm for biotechnology’s potential is tempered, however, by fear that the consolidation of genetic knowledge and expansion of biotechnology markets will merely create new opportunities for marginalization and exploitation. Without genuine partnership between scientists from the industrialized nations of the North and scientists of the South, as well as

<sup>31</sup> Allyn L. Taylor, “Globalization and Biotechnology: UNESCO and an International Strategy to Advance Human Rights and Public Health,” *American Journal of Law and Medicine* 25 (1999) 479–541.

<sup>32</sup> Abdullah S. Daar, Halla Thorsteindottir, Douglas K. Martin, Alyn C. Smith, Shauna Nast, and Peter A. Singer, “Top Ten Biotechnologies for Improving Health in Developing Countries,” *Nature Genetics* 32 (October 2002) 229–32. See also *Genomics and World Health*, The Advisory Committee on Health Research, World Health Organization (Geneva: WHO, 2002).

binding international agreements governing access to technology and information, there is concern that the biotechnology revolution will merely exacerbate the “10/90 gap,” i.e., the existing situation wherein 90% of health research dollars are spent on the health problems of 10% of the world’s population, and, at worst, divert attention and resources for what Tikki Pang calls the “core issues of global public health, such as provision of clean water, safe food, proper sewage disposal, decent housing and access to maternal and child care.”<sup>33</sup>

Calls for protection and partnership are often put in the form of appeals to human rights, as Taylor does above, the sort of appeals one saw in debates over the allocation of resources for AIDS. The “inherently international and collaborative” character of genetic research, its setting within the multilateral effort of the Human Genome Project, and the dissemination of associated benefits and burdens across populations and generations, seems to many people to lend itself to arguments for genomics as an obvious “global public good.”<sup>34</sup> Joining ethics, public health, and human rights discourse has the advantage of expanding the moral field beyond issues such as informed consent and the limits of intellectual property to include equity in confronting disease threats and the methods through which strategic priorities for health care will be set—in other words, it expands the moral field beyond its Western preoccupations. Unfortunately, invoking the contested language of “human rights” or “public goods” in this context also opens more questions than it settles. Rather than delimiting the terms of debate to a single shared language, it highlights the coexistence of multiple and perhaps incommensurable moral languages.

Controversies over access to affordable AIDS therapy and the meaning of justice in the genetic age illustrate how traditional distinctions between domestic and international arenas in bioethics are giving way in the face of globalizing pressures. They also make clear the challenges involved in attempting to construct a “global bioethics,” to find a compelling moral grammar for international cooperation around issues of common concern. I turn now directly to what this emerging global consciousness means for developments in method.

### BIOETHICS “FROM BELOW”

Godfrey Tangwa has observed that: “[t]he globalisation of Western technology should not be accompanied by the globalisation of Western ways of

<sup>33</sup> Daar, et.al., “Top Ten Biotechnologies for Improving Health in Developing Countries”; Tikki Pang, “Equal Partnership to Ensure Developing Countries Benefit from Genomics,” *Nature Genetics* 33 (January 2003) 18.

<sup>34</sup> Das, “Public Good, Ethics, and Everyday Life: Beyond the Boundaries of Bioethics” 101.

thinking and acting, Western ways, manners and style of doing things, Western idiosyncrasies and eccentricities. Other cultures should be able to beg, borrow or buy Western technology without having to take it along with all its Western packaging, its entire surrounding value system."<sup>35</sup> His characterization of the bargain faced by non-Western, economically weaker peoples in seeking to share in the technological and scientific developments led by the West captures a theme running through the growing literature in bioethics from the two-thirds world, namely the desire to draw what is best from surrounding advances in knowledge and ability without unreflectively importing "all its [frequently] Western packaging." As distinctive voices from the South have emerged in bioethics, it has been with a clear eye to the reality that, for the most part, the globalization of bioethics (i.e., the development of its aspirations as an international, intercultural discipline) has been equivalent to the "the globalization of Western ways of thinking and acting."

The recent collection of essays written in the context of the Philippines, *Beyond a Western Bioethics: Voices from the Developing World*, cited above, reflects self-consciously and critically on the dominant methods and languages of contemporary bioethics.<sup>36</sup> It demonstrates a nascent effort to articulate a distinctively Filipino bioethics, responsive to the particular material conditions within which health-care choices will be made and consonant with Filipino religious and cultural values. The volume provides an especially interesting look at the limitations of "principlism" as it encounters what editors Angeles Tan Alora and Josephine Lumitao call "the lived phenomenology of the Filipino context."<sup>37</sup> Alora and Lumitao were participants in a series of training exercises, conducted by experts from the United States, aimed at developing local capacity in bioethics. Alora and Lumitao "found their voice," as it were, in experiences of cognitive dissonance, in which the presuppositions of neutrality and universality that framed the exercise were at odds with their own moral experiences and intuitions.<sup>38</sup> They describe the clash of Western and Filipino moral world views:

<sup>35</sup> Godfrey B. Tangwa, "Globalization or Westernisation? Ethical Concerns in the Whole Bio-business," *Bioethics* 13 (July, 1999).

<sup>36</sup> *Beyond a Western Bioethics*, ed. Alora and Lumitao; see n. 28 above.

<sup>37</sup> *Ibid.* 19.

<sup>38</sup> The observation is frequently made that an indigenous or local bioethics tends to develop as a second stage, as moral languages and methods that were imported from the United States and Europe are subject to scrutiny in light of cultural traditions and circumstances. See, e.g., Debora Diniz, "Feminist Bioethics: The Emergence of the Oppressed," in *Globalizing Feminist Ethics*, ed. Rosemary Tong with Gwen Anderson and Aida Santos (Boulder, Colo.: Westview, 2000) at 67, for a critical account of the adoption of (and critique of) principlism in Brazilian

The very character of ethics in the West contrasts with ethics in the Philippines not just in terms of the issues and solutions, as well as the context in which each is embedded, but also in the very language and character of moral concern. The focus of Western bioethics is individual; elsewhere it focuses on social units. Western bioethics often is oriented to principles; Filipino bioethics, on the other hand, is not articulated primarily in principles but in lived moral virtues. Whereas Western bioethics is almost always expressed in discursive terms, Filipino bioethics is part of the phenomenological world of living experience. For the West, bioethics is a framework for thought, a conceptual system. For the Philippines it is a way of life, an embodied activity of virtue.<sup>39</sup>

Four themes emerge in this collection and elsewhere in the literature of bioethics from the two-thirds world that are helpful in framing a “bioethics from below.” The first theme is a critique of the pride of place given to respect for individual autonomy in health-care decision-making and policy recommendations. As Alora and Lumitao note: “Within developing countries, society, family, and church assume a moral and religious significance no longer found in the West. In traditional societies, the family takes for granted values such as authority, obligation, honor and caring.”<sup>40</sup> In Filipino culture, “the family is considered to be the social unit of greatest value.”<sup>41</sup> This is not to say that respect for individuals drops out of moral view, but rather that any approach that fails to appreciate the way in which persons are constituted as moral selves by virtue of their familial relationships will fail to respect individuals. According to Alora and Lumitao, “given this strong family ethos, the primary locus of assessment of the good is not the individual but the family . . . [m]aintenance of harmony within the family and among peers take precedence over other concerns for social justice or honesty, which from this perspective appear to be anonymous formal principles that are disengaged from concrete moral community life.”<sup>42</sup> Given a family-centered and community-centered ethos, “Western ideals of individualism and self-reliance have little purchase in the Filipino culture.”<sup>43</sup> As two other contributors to the volume, Letty Kuan and Tamerlane Lana, explain: “family values and community ties that generate

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bioethics; also, Akira Akabayashi and Brian Skigsby, “Bioethics in Japan: The Second Stage,” *Cambridge Quarterly of Healthcare Ethics* 12 (2003) 261–64.

<sup>39</sup> *Beyond a Western Bioethics*, ed. Alora and Lumitao, 4.

<sup>40</sup> *Ibid.* 3. See also Godfrey B. Tangwa, “The Traditional African Perception of a Person: Some Implications for Bioethics,” *Hastings Center Report* 30 (2000) 39–43. Tangwa contrasts an African concept of personhood (as “eco-bio-communitarian”) with a Western notion of the self-determining, independent, rational subject.

<sup>41</sup> *Ibid.* 7.

<sup>42</sup> *Ibid.* 8.

<sup>43</sup> *Ibid.*

*pakikisama* (harmony with others) and *utang na loob* (gratitude) . . . play a significant role in Filipinos' moral judgments."<sup>44</sup>

Attending to the familial context for moral agency shifts the landscape for the practical concerns of bioethics: "Filipino bioethics as a lived ethic does not focus on individual consent to health care, individual confidentiality, or individually articulated concerns with beneficence, caring, and truth-telling."<sup>45</sup> Obviously, this has important implications for what will be important in public health initiatives, e.g., to address the spread of HIV/AIDS or to allocate access to genetic technologies. Among other critical issues will be the question of how to conceptualize informed consent so as to respect the value of the family or the community, and how to determine what constitutes "authentic" moral agency for persons variously situated within families and communities.<sup>46</sup> Equally important will be how to ensure that the deference to authority that is a prominent feature of this moral ethos does not translate into misuse of professional authority.

Recognizing the presence of distinct moral world views and different moral languages across cultures underscores the importance of building community partnerships in global public health and international research strategies. Added to obstacles posed by cultural and linguistic differences (e.g., the absence of local words for "placebo" or "randomization" ) is the challenge of understanding the flows of communication and authority within a community. It is clear that developing local capacity in bioethics cannot mean merely importing established roles, principles, and practices. Rather, it must entail creating conditions for mutual exchange and genuine reliance on local experience and expertise. Karim Abdool gives an example of this partnership approach in the South African context:

In rural Hlabisa, South Africa, HIV researchers undertook an extensive process of community consultation that culminated in the establishment of a Community Advisory Board. The board has taken the initiative to employ eight local people as community educators, to develop educational materials, consult with and inform the community about each new research project, and provide advice to researchers about local needs for the ethical conduct of research.<sup>47</sup>

<sup>44</sup> Letty G. Kuan and Tamerlane Lana, O.P., "Conscience and Health Care Practices: The Case of the Philippines," in *Beyond a Western Bioethics* 52–60.

<sup>45</sup> *Ibid.* 15.

<sup>46</sup> See also, Sivaram, "AIDS Care and Human Rights in Rural India: Translating Policy Into Practice," 216; and Insoo Hyun, "Waiver of Informed Consent, Cultural Sensitivity, and the Problem of Unjust Families and Traditions," *Hastings Center Report* 32 (2002) 14–22. In "AIDS in the Developing World: The Case of the Philippines," in *Beyond a Western Bioethics* 81–88. Lumitao points out that the strong family system in Filipino culture undermines respect for confidentiality which has implications for the willingness of people to undergo HIV testing,

<sup>47</sup> Karim, "Globalization, Ethics and AIDS Vaccines" 2129.

A second theme that emerges in this collection and elsewhere is a critique of Western hubris about the “purity” of ends and results of moral and political action. As one sees in international debates over ARV and HIV/AIDS vaccine trials, there tends to be a greater appreciation of the ambiguity of action and a greater acceptance of a less than ideal outcome in the face of few or no alternatives. To make this point, Alora uses the case of “medical missions,” where medical students from abroad perform procedures for underserved patients that would be performed by specialists in circumstances where there are greater resources. Alora admits that patients receive “less than the standard of care.” However, she argues:

In the Philippines, where more than half of the population is below the poverty level and 60 percent never see a physician, such efforts to alleviate the suffering of the poor should be lauded. Usually, medical care is not an “all or nothing” matter—either the best or worthless. Even medical students who are providing less than the best care may be able to provide acceptable care. With proper supervision, they can certainly provide care that is better than no care.<sup>48</sup>

Using an argument akin to those used to defend placebo use in HIV/AIDS research in the two-thirds world, Alora writes:

The brutal truth of the matter is that in the health care policy of the developing world, the choice often is between insisting on the standard of care established in the developed world—which will deny most of the poor any treatment—or accepting a double standard of health care: one for the middle class and rich and one for the poor. If one accepts the latter choice as inescapable, one must insist that while giving less than the best care, one still should remain committed to doing the best one can under less than optimal circumstances. Although the best can be the enemy of the good, while giving less than the best one should still commit the best of one’s moral attention.<sup>49</sup>

Notable here is a kind of “prophetic resignation”: the acceptance of limitations on moral possibilities that nonetheless requires opposition to the forces constraining agency as well as vigilance in scrutinizing the quality of one’s response within those limitations.

A third theme is a critique of the emphasis in international debates in bioethics on law, regulation, and policy to the exclusion of what could broadly be called the contextual or “public health dimensions.” Commenting on the way the ethics of HIV/AIDS research has been discussed, Zulfiqar Bhutta observes: “[W]hile issues of study design, ethical review, and standards of care have been highlighted, the underlying socioeconomic deprivation and inequalities are largely ignored . . . [W]hile the concerns about research in developing countries have brought a welcome focus on this long-neglected area, the focus has been on regulatory issues, rather than on the basic problems that underlie the inequities in health and hu-

<sup>48</sup> Angeles Tan Alora, “The Virtues and Vices of Dumping,” in *Beyond a Western Bioethics* 121–22.

<sup>49</sup> *Ibid.* 122.

man rights in developing countries.”<sup>50</sup> One consequence of this relative inattention to context is that the moral geography is often impoverished or distorted. As Alora and Lumitao argue, debates over policy for research or access to treatment frequently overlook the fact, e.g., that in developing countries, “several worlds of medicine may exist simultaneously; . . . affluent worlds versus survival worlds . . . first, second, third, and even fourth worlds of health care.”<sup>51</sup> A related consequence is that differential vulnerabilities and burdens under the threat of disease are obscured. We see something of this in Lawrence Gostin’s admission of Western bioethics’ failure to attend to the particular intersection of gender and poverty in the experience of HIV/AIDS: “It is difficult to believe that only a few years ago, the bioethics community in North America focused on the ethics of clinical trials of short-course HIV treatment, rather than the unconscionable burden of disease among African women and children.”<sup>52</sup> The increasing visibility of women and children in the contours of the HIV/AIDS debate is hopeful. However, as Margaret Farley argued in her 2002 Madeleva Lecture, no real gain will follow until the many forces (religious as well as social and economic) that shore up gendered discrimination and result in women’s lack of economic, political, and social power (and therefore constrain choices about prevention and treatment) are acknowledged.<sup>53</sup>

A fourth and final theme to note is the incorporation of narrative in a “bioethics from below.” One cannot help but be struck by the frequent use in this literature of story, poetry, and song to convey moral experiences and concerns. Cumulatively, the turn to narrative has the effect of *decentering* bioethics, not only by bringing to light features of moral analysis that do not necessarily enter into principle-based reasoning, e.g., the role of various kinds of intimate and non-intimate relationships and networks of care or neglect, but also by effecting the shift Alora and Lumitao identified as the turn from the discursive to the phenomenological. The temptation to use narrative in introducing an alternative moral framework, to draw an

<sup>50</sup> Bhutta, “Ethics in International Health Research: A Perspective from the Developing World” 116.

<sup>51</sup> Alora and Lumitao, “An Introduction to an Authentically Non-Western Bioethics,” in *Beyond a Western Bioethics* 3.

<sup>52</sup> Lawrence O. Gostin, “AIDS in Africa among Women and Infants: A Human Rights Framework,” *Hastings Center Report* (September–October, 2002) 9.

<sup>53</sup> Margaret A. Farley, *Compassionate Respect: A Feminist Approach to Medical Ethics and Other Questions*, 2002 Madeleva Lecture in Spirituality (New York: Paulist, 2002). See also, Wang Jin-Ling, “HIV/AIDS and Prostitution in Mainland China: A Feminist Perspective,” in Tong, *Globalizing Feminist Bioethics*, 238–46; *Catholic Ethicists on HIV/AIDS Prevention*, ed. James F. Keenan (Washington: Georgetown University, 2000); Marcio Fabri Dos Anjos, “Medical Ethics in the Developing World: A Liberation Theology Perspective,” *Journal of Medicine and Philosophy* 21 (1996) 629–37.

interlocutor into one's moral universe—and the effectiveness of this turn—is at least a suggestion of what might be necessary for a cross-cultural or global bioethics.

This look at the challenge to bioethics from voices outside of North America and the industrial North leaves many questions unaddressed, e.g., the place of cultural critique and the possibilities for international oversight of new technologies. What should be clear, however, are the limits of Western bioethical paradigms as we move across cultures, the importance of inviting a variety of voices and perspectives into the debate about science, medicine, and technology as their reach extends and the scale of the problems we face expands, and the need “to reconceptualize bioethical theory to address the intersection of local and global concerns.”<sup>54</sup> It should also be clear how the landscape in bioethics shifts when we begin to admit a “bioethics from below,” i.e., a bioethics not of the privileged but of the marginalized. Before concluding, I want to consider the intersection of theological ethics and contemporary challenges to Western bioethics.

### THEOLOGY AND THE CHALLENGE TO A WESTERN BIOETHICS

Theologians have given a fair amount of attention to the implications of globalization and the possibilities for a global ethic.<sup>55</sup> It is not necessary to review those efforts here or to resolve all the problems posed by globalization for ethics and theology. In this concluding section, I want merely to suggest three points of contact between contemporary Christian ethics and the critique of Western bioethics that we have seen in order to ask, in a preliminary way, where we might begin *theologically* in the construction of a global bioethics (or a “bioethics from below”).

#### Social Anthropology

There is a long tradition of attention to sociality and the obligations of community in Christian ethics, alongside a more recent critique of the ideals of atomized individualism frequently associated with contemporary liberalism (and, by extension, bioethics). In various ways, one of the distinctive contributions of theology to bioethics since its birth as a discipline has been to call attention to the social, spiritual, and cultural dimensions of choices concerning health and medicine. Alora and Lumitao's sensitivity to the importance of the bonds of family in an account of a good human life—and the role of the family in medical decision-making—is deeply

<sup>54</sup> Anne Donchin, “Introduction,” in *Globalizing Feminist Bioethics 2*.

<sup>55</sup> See Jean Porter, “The Search for a Global Ethic,” *Theological Studies* 62 (2001) 105–22; Lisa Sowle Cahill, “Toward Global Ethics,” *Theological Studies* 63 (June 2002) 53–77.

informed by Christian anthropology and its commitment to the inherent sociality of human flourishing. Under the influence of liberation theology, contemporary Christian ethics has also paid considerable attention to the problem of social or structural sin, i.e., those institutionalized patterns of relation (social, economic, political, and ecclesial) in which individuals and groups become and remain marginalized. As Marcio Fabri Dos Anjos argues, it is precisely from a liberation perspective that one sees how clearly how “social injustice permeates medicine.” In other words, it is through this lens that concerns about social justice of the sort being raised by the rising voices of the South become “primary subjects of medicine rather than derivative concerns.”<sup>56</sup>

The special challenge for a theological global bioethics is to be self-critical about the role of families and communities (including faith communities) in creating conditions of unequal and dangerous vulnerability for individuals or groups of individuals, e.g., conditions whereby the world’s women are differentially vulnerable to HIV infection and death from untreated AIDS. As Margaret Farley reminds us: “It would be naive to think that cultural patterns that make women vulnerable to AIDS are not influenced by world religions whose presence is longstanding in their countries. Fundamentalisms take varied forms, but many of them are dangerous to the health of women.”<sup>57</sup>

### Partnership for Justice

Lisa Sowle Cahill, in a recent article in the *Journal of Religious Ethics*, notes that “Christian theological bioethics is increasingly making distributive justice in health care resource allocation, especially in the form of affirmative action on behalf of historically excluded populations, its priority.”<sup>58</sup> Indeed, against those who argue that theology is marginal to contemporary bioethics, she argues that an active commitment to justice is and should be the way theology counters most effectively “the equally thick cultural traditions of modern science and market capitalism.”<sup>59</sup> “Theological bioethics must take shape in broad, inclusive, participatory, and ultimately global networks that bear out the conviction that more just practices are not only obligatory but a ‘possible impossibility’.”<sup>60</sup> Cahill argues that traditions of social activism alive in Christian churches provide a base for envisioning and actualizing multilateral cooperation around programs

<sup>56</sup> Anjos, “Medical Ethics in the Developing World” 632.

<sup>57</sup> Farley, *Compassionate Respect* 17.

<sup>58</sup> Lisa Sowle Cahill, “Bioethics, Theology, and Social Change,” *Journal of Religious Ethics* 31 (2003) 363–98.

<sup>59</sup> *Ibid.* 363.

<sup>60</sup> *Ibid.* 391.

and policies for ensuring access to health care and an equitable share of the benefits of scientific progress, e.g., in the area of human genetics. Cahill does not resolve all the problems that attend aspirations toward a global bioethics. She looks, rather, to the promise of international strategic alliances that take their energy from what could be called the identification of “commonalities between different resistances to oppression,”<sup>61</sup> in this case, common resistance to the force of consolidated market and scientific ideologies.

### Option for the Poor

Many people would agree with Farley that “[i]f ever there was a situation in which the principle of Preferential Option for the Poor was relevant and crucial, it is difficult to think of one more dramatic than the AIDS pandemic in the South.”<sup>62</sup> We could extend her observation to add that it is difficult to think of a time when a commitment to examine social, political, economic, scientific, and medical choices from the perspective of the least well-off (the two-thirds world) was more urgent. As the voices of the peoples of the South are heard in bioethical debate, they emerge as a call to draw not only from the rich tradition of theological concern for the poor, but, as Cahill argues, the rich tradition of active, committed solidarity in advocacy for the poor.

Feminist philosopher Rosemary Tong argues that “if global bioethics is a possibility, it will be because we agree to see each other not through the eyes of justice blindfolded and holding a sword and scales, but through the open eyes of the Greek goddess Nemesis—she of the ‘third eye’—continually looking for wrongdoers, for oppressors.”<sup>63</sup> To “opt for the poor” in the context of global health is to develop the capacity and the desire to see through “the third eye” on behalf of and alongside of all those who, sharing our humanity, remain at the margins through poverty, injustice or disease. The debates over how to best articulate the demands of justice for the poor as the world grows smaller and as the interdependence of persons, environments, and technologies appears more evident have only just begun—whether or not, as many argue, the language of human rights is in the end the most fitting global framework for making visible the mutual vulnerabilities and potentialities served by science and medicine—but it seems that this is our most urgent theological and spiritual obligation.

<sup>61</sup> Fiona Flew, et.al., “Local Feminisms, Global Futures,” *Women’s Studies International Forum* 22 (July 1999) 393–403, at 393.

<sup>62</sup> Farley, *Compassionate Respect*, 18.

<sup>63</sup> Rosemary Tong, “Is a Global Bioethics Possible as Well as Desirable?” in *Globalizing Feminist Bioethics* 27–36.

## CONCLUSION

It is sometimes argued that health is the only universal aspiration. Whether or not that is correct, human beings all share the limits and possibilities of embodiment and so are equal in their most fundamental relationship to the promises of science and medicine. The task of bioethics is to provide tools for ensuring that the public goods of medicine and biotechnology—now *global* public goods—serve everyone.”<sup>64</sup> However, it is increasingly obvious that bioethics must account not only for what is shared and in need of sharing—what was once just assumed to be universal—but what is particular and understandable only from the “homeplace.” The challenge is not only to rethink frameworks and rework concepts in light of a richer, more complex sense of the moral field, although that is important, but here, as elsewhere, to give voice to those without power and influence but whose fate depends on us all.<sup>65</sup>

<sup>64</sup> Ibid. 35.

<sup>65</sup> I wish to thank Bill Bolan and Elizabeth Agnew for research assistance in the preparation of this article.